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ABSTRACT

Dysfunctional relations between the family and other social systems usually play a part in maintaining refractory problems and chronic patienthood. Therapeutic interventions need to work at this interface, in order to create a collaborative team that will provide sufficient support to the family at risk. This way of working can be easily applied in the highly organized community of the kibbutz, but the same principles have also been applied with urban patients. Members of the extended family, friends, close neighbors, members of the environment, physicians, and community agencies can become important therapeutic allies once it is learned how to coordinate their resources. In applying this approach therapists need to maintain contact with members of the community, and to find ways of involving them with the family, while at the same time taking care to respect family boundaries. This is a complex way of working, especially since the therapist needs to use a wide variety of techniques and apply them to different levels of the system. However, the intensive concentration of efforts during a crisis often enables the family to muster inner resources, eventually dealing with the problems in a more independent way. (A case study of a 17-year-old female suffering from epilepsy is included.) (LLL)

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A COMPREHENSIVE APPROACH TO REFRACTORY MIND-BODY DISORDERS: WORKING AT THE FAMILY-COMMUNITY INTERFACE*

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* The ideas described in this paper are rooted in a therapeutic approach that has been developed in the Kibbutz Child and Family Clinic by Mordecai Kaffman. The application to refractory mind-body disorders was done in collaboration with Mordecai Kaffman. We also worked together in the case that is described in the paper: he was the medical consultant, and the author was the systems therapist.

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A COMPREHENSIVE APPROACH TO REFRACTORY MIND-BODY DISORDERS: WORKING AT THE FAMILY-COMMUNITY INTERFACE*

ABSTRACT

Family therapy is always embedded within a larger social context, but the clinical implications that this context may have on the therapeutic process have not been sufficiently examined. This paper begins by looking at some of the dysfunctional dynamics among families, therapists, and social-medical systems, when a family presents with a refractory disorder. These critical observations are then expanded into a framework for multileveled intervention. In the presentation of this framework particular emphasis is placed on devising ways of working with families in close collaboration with larger systems, ways that empower and support stuck families and their therapists when family therapy is not enough.

A COMPREHENSIVE APPROACH TO REFRACTORY MIND-BODY DISORDERS: WORKING AT THE FAMILY-COMMUNITY INTERFACE

Has the term "family therapy" become a misnomer? Therapists who work with a systems model orientation have been growing more and more dissatisfied with popular formulae attempting to describe the impact of family dynamics on the shaping and stabilizing of symptoms (4, 12). Important dynamics take place at other levels of the ecology in addition to the family level, and at the interfaces among these different levels as well. These may all be salient to a particular course of therapy. A therapist who fails to assess and address biological deficits for example, may inadvertently add to the burden and pain experienced by families (10, 14). As stated by Bloch, the therapist can thereby become a part of the problem-defined system, one more factor in the multilevel patterns that, in fact, maintain the disorder (2).

During the last decade, publications in family therapy have been showing a growing interest in the role played by social and medical systems and have been searching for ways to incorporate this insight into clinical practice (13, 9, 15). However, in Elizur and Minuchin's longitudinal observations of the actual field work of experienced family therapists, a significant gap was found between theoretical development and clinical practice (6). Since this gap has some important implications for working with refractory disorders, this paper will begin by elaborating on some of that study's observations and insights. Then the effectiveness of a comprehensive approach to family therapy that includes the family-community interface will be demonstrated for a case involving an adolescent epileptic girl.

Our study was based on an intensive follow-up of four families during a five year period. The therapists were all well established family therapists and supervisors. Professional consultation at the beginning of the follow-up process was provided by Minuchin. Therapies were assessed by repeated interviewing of both therapists and families. The presence of two major dysfunctional patterns that influenced the long term development of some of the cases became apparent:

1. A fragmentation of the therapeutic ecology: Although all therapies began with clear systemic guidelines, there was a tendency toward fragmentation among the various subsystems in contact with the family, a kind of entropy that prevailed over time despite many efforts and good intentions. 'Agency triangles' such as described by Carl and Jurkovic (3) emerged; muddles occurred in communications among therapists from different institutions; power struggles developed between therapists and parents, and a striking lack of continuity of care seemed to characterize the most complex and chronic cases.

2. Biases and blind spots in therapeutic outlook: Therapists tended to overemphasize one level of the problem while other important issues were left unattended. Usually they were not aware of their biases and proceeded as if their diagnoses were objective portrayals of reality. Family therapists, for example, tended to overfocus on the family as the unit of observation, thereby excluding other significant systems. Many were also biased by their involvement in their own larger system of work, tending to emphasize the functioning of the identified patient, for example, and to overlook the difficulties of other family members.

With the historical perspective of a follow-up study, it was possible to map a developmental continuum in the direction of increasing chronicity. This was a path that was

defined not only by the family and therapists, but also by social organization and cultural traditions. The progression (or regression) promoted rigidity in labeling and family script, severe underfunctioning of the patient in more than one important life area, a skewed family organization which developed in order to deal with the disabled patient, and heavy involvement, with the patient, of social and/or medical services. In its most pathological form, such a process culminated in family dismemberment. In spite of this, the family evolutionary process did not imply one definite end point common to all families. Even the most chronic and rigid family systems did, by the end of our study, reach the flat type of existence usually associate with the term chronic; all families continued to experience crises, and hence to evolve toward either greater health or greater pathology.

We focused on these points of crisis since we found that the coping mechanisms brought to bear were pivotal in the life course of families and therapeutic systems. The social systems involved with each case played an important role in this process. While these systems were involved in the dysfunctions, they were also reservoirs of crucial resources that could help families resolve the crises successfully. The ability to use such resources depended, to a large extent, on the therapists' way of working with the family-community interface, and this was influenced by the presence or absence of the two dysfunctional patterns mentioned above.

Attempting to apply these insights to my own supervisory work with therapists handling rigid and chronic cases, I have found the following two questions to be particularly relevant: 1. What therapeutic possibilities can be realized by working with the social systems that are already involved or that can become involved with the case? 2. What are the practical means for doing clinical work at this level? It is important not to be biased by the information and opinions that is provided by the therapist, the family, or anyone else. It is

always too easy to overemphasize one level of the ecology, and within the confines of such a focus, to create a limited therapeutic narrative that nevertheless, seems to fit perfectly.

The case presented here demonstrates how a crisis situation can be used to initiate a collaborative treatment program between the family and social systems in the community. It is typical of the refractory cases referred by physicians and therapists to the Medical Psychology Center of the Kibbutz Clinic. The referral usually occurs when the therapist feels stuck and there is a crisis with severe somatoform symptomatology. This case illustrates how working with the family-community interface helps the therapist to deal with the crisis, enabling the therapeutic process to unfold in a less pressured atmosphere.

WHO IS INVOLVED IN KAREN'S EPILEPSY?

Karen, 17, had already been in therapy twice prior to her referral for consultation. Although the therapies had been individually oriented, they had also involved Betty, the 46 year-old mother, and David, age 15. Karen's father died when she was three.

At age 10, Karen developed temporal lobe epilepsy and was hospitalized because of severe and frequent episodes of grand mal. However, the hospital's report also referred to "some observed psychomotor seizures that had a significant functional component". At that time Betty had become romantically involved with a man and was thinking of remarrying. Karen, and to a lesser degree her younger brother, reacted with extreme resistance to the man. A few months afterwards the mother ended the relationship, mainly because of the children's continued resistance.

After her release from the hospital, Karen was treated by the best specialists and a wide variety of drugs were tried with her, but the seizures continued to occur once or twice a

week. She seemed to adjust to her condition and the environment accommodated to her. Karen was a good student, and though her classmates were somewhat afraid of her seizures, she was also respected for her contributions to the school's cultural program. The problems were mainly in her relationship with her mother, which had become quite stormy during adolescence. They had some family sessions, and at age 15 Karen began individual therapy while Betty went to a women's group.

A marked deterioration occurred when Karen was 16. Betty, after a year of group therapy, was now saying in an assertive way that she wanted the children to be considerate of her needs too. She formed a serious relationship with Dan, a divorced man. Within a couple of months, he came to live with Betty and the children, and the couple was planning to marry.

In the beginning Karen became very attached to Dan; they had long talks and she sought his advise for every small problem that she had. At times it even seemed as if she was competing with Betty for his attentions. Dan and Betty tried to accommodate, but Karen's querulousness toward her mother was increasing without bounds. When Betty tried to have a gentle talk with her, Karen was offended, insisting that she was interfering with her mother's quest for a new life. At the same time, the frequency and severity of her seizures increased dramatically. It reached the point where Betty was called out of work every day to take care of Karen; the recovery time after each seizure was also increasing. Betty tried to be attentive and supportive, but the situation deteriorated, the fights with Karen becoming more frequent. The neurologist increased the medications. This helped with the seizures, but Karen became very drowsy, unable to concentrate on her studies. She stayed home most of the day and began to talk about suicide as a way of helping the family and stopping her own misery. Betty reacted with extreme anxiety and guilt, trying to be with Karen most of

the day. The crisis continued to escalate with Karen barely leaving the home. Psychiatric hospitalization was considered. The referral to us was initiated conjointly by the therapist, the mother, and the kibbutz school who all wanted to find a way to resolve the crisis within the community.

The family dynamics seemed clear, and the central issues were obviously related to the difficult transition from a closely connected unit of a mother and two children, to a complex blended family. The crisis was also influenced by the fact that Karen was an adolescent who was oscillating between dependence and independence, sometimes demanding while at other times cutting herself off from emotional contact and support. Karen, no doubt, suffered from epilepsy, but her symptomatology was the product of intertwined biological, psychological, familial and social processes in a way that has also been found among pseudoseizure patients (8). In Grifith's study of 27 pseudoseizure patients it was found that symptoms such as Karen's were frequently maintained by multiple patterns. For example, a psychophysiological pattern could occur side by side with a detouring pattern.

However, the narrative that was presented up to this point was constructed by using information provided by the therapist, and her emphasis was on the family and Karen's individual dynamics. There were some hints that other systems were also playing a part in the problem. To broaden the therapeutic perspective the following people were invited to the consultation in addition to the four family members and the therapist: the homeroom teacher, the *metapelet* (the group's caretaker who is involved with all the after-school activities), the school counselor, the school nurse, the kibbutz nurse, and the neurologist. It was a three-hour session that was divided into parts for meeting with the different subgroups.

We also saw all of them together for a summing-up at the end.

The outstanding characteristic of our meeting with the family was everyone's high degree of involvement and anxiety concerning Karen's illness, and the way that Karen was using her symptoms for control. She entered the room leaning heavily on Dan, demonstrating her physical weakness and dependence on others in an almost histrionic way. Later, she provocatively spoke about the risks that she used to take, such as going to the pool to swim alone and riding on a motorcycle. Betty swallowed the bait, reacting with anxiety and reprimands that Karen laughed at, the way that some adolescents ridicule their parents when they get them worried and then tell them not to interfere. Dan thought that Betty should be more firm with Karen, but he did not know how much he should get involved in their relationship. He tried to navigate a difficult course: he was angry at Karen's possessiveness of Betty, but he was also afraid of alienating Karen, wishing to keep their friendship and to give her the support she needed. There was also David, who did not wish to be too involved with his sister; he wanted to go on with his own life, safely distanced from her "abnormality".

In addition to the family dynamics, our broadening of the therapeutic system revealed six other issues:

1. Karen's functioning in school deteriorated during the last year to a point that significant gaps in knowledge were created. Her teachers were forgiving because of her medical condition. The homeroom teacher, who was new to the school, did not know how much to expect of her, nor did she dare to confront Karen. Karen demanded special accommodation, resisting all the attempts to increase the level of expectations from her.

2. In contrast to the teacher, the *metapelet*, who had been with the group for over three years, stated bluntly that Karen was using her condition to avoid responsibilities.

Indeed, Karen, unlike her peers, did not accept responsibility for any chores in the school quarters even before her condition became very acute. She also did not participate in any extra-curricular activities. The *metapelet* continuously tried to confront Karen, but to no avail. Karen would be supported by her mother in this conflict, and the *metapelet* blamed Betty for undermining her authority. Their relations were strained.

3. Two nurses were involved with Karen and they seemed to take different approaches concerning her disability. The school nurse thought that as soon as possible after a seizure Karen should go back to class. The kibbutz nurse had a softer approach, and Karen tried to get her support whenever there was a confrontation with the school authorities. This nurse was also a friend of the mother. It was not clear which nurse was responsible for Karen.

4. Karen was socially isolated. Her frequent seizures created much fear among other students, and she seemed to be living in her own territory. She declared that she was uninterested in the "childish" topics with which her classmates were concerned. At times she lectured them at length about epilepsy. In the beginning they were interested, but they soon became bored with this one-topic conversation. They thought that she was strange.

5. Indeed, as Karen was doing less and less at home and school, her energies became increasingly focused on her illness. This was no doubt helped by a special relationship that she developed with her neurologist. They met frequently to try different medications, talking at length about epilepsy and many other personal issues. Karen thought of him as a friend, and she once appeared with him on a radio program about epilepsy. This privileged relationship with him was obviously a boost to her self-image, and she sometimes went on special trips (two hours each way) just to have a talk with him. When the consultation was arranged, he agreed to attend, saying that he felt troubled by the

relationship.

6. The psychologist who was working with Karen during the last year used an individual psychodynamic approach. She felt frustrated because Karen kept talking in the sessions about her illness, and the therapist did not feel that any attachment had formed between them. She tried to work with the family, but as the situation became very tense and there were threats of suicide, she asked to transfer the case to the medical psychology center.

As shown here, a disposition toward a comprehensive multileveled evaluation of cases often leads to the procuration of additional valuable clinical data and the uncovering of unexpected complexities.

A FRAMEWORK FOR ECOSYSTEMIC INTERVENTIONS

The crisis intervention in Karen's case focused on reducing the amount of anxious attention given to her illness and promoting a greater involvement with her studies, her work and her peers. We thought that if the ecosystem would be integrated, then it would be possible to maintain reasonable limits while also supporting Karen's competence and autonomy. The creation of this context in the community was to be the first step. Once created, it would facilitate communication in the family about the changes that they were experiencing, enabling negotiations about their needs and expectations without using the language of psychosomatics.

The approach to this case illustrates our model for working with the family and social-medical systems when they are at an impasse involving a refractory mind-body disorder (5). The guidelines for intervention have four general directions: the creation of a collaborative

therapeutic team, changing ecosystemic patterns that maintain the dysfunction, the use of social resources in support of the family and the patient, and clarifying boundaries between the family and the involved social systems.

The Creation of a Collaborative Therapeutic Team:

Two elements are mandatory for good teamwork: a clear and accepted leadership, and the ability to closely monitor the implementation of the therapeutic program. The systems therapist's task is to integrate and lead the ecosystem, and this is indicated in the way that the consultation is set up, in the delineation of the therapeutic blueprints, and in the handling of resistances and conflicts. It is an attitude on the part of the therapist, the assuming of a position that takes place on the process level of the consultation, and it becomes a clear part of the therapeutic contract.

In the case under discussion here the therapy, in addition to the blended family, needed to encompass the following systems: the school, the peer group (which is particularly important in the kibbutz way of life), the medical team, and the therapist. Eleven people participated in the first consultation. Later, it was found necessary to involve five more people: a coordinator, and Dan's three children and ex-wife. Without the collaboration of such a large group, the different factions, each aware of only one aspect of the problem would have continued their fighting, making it impossible to implement even the most circumscribed interventions for coping with the immediate crisis.

Clearly, before this session no one took responsibility for preparing and implementing a comprehensive intervention program. Supporting the attempt to create a coordinated ecosystem was the fact that the crisis was felt by everyone involved with Karen, who had all applied a variety of possible solutions to no avail. By coming to the initial consultation, they

made a commitment to try a new strategy. The coordinated approach, in fact, was experienced to be respectful of their different needs, to provide a clear explanation to the overwhelming complexity of the situation, and to suggest a way out. These are most powerful non-specific effects of psychotherapy (7) and they have a particularly great impact during a crisis, when people feel demoralized by the impasse. As Jerome Frank put it: "The core of the techniques of healing... seems to lie in their ability to arouse the patient's hope, bolster his self-esteem, stir him emotionally, and strengthen his ties with a supportive group" (p. 76). The "patient" can be the ecosystem.

The coordinator

In complex clinical situations that involve many individuals, the appointment of a coordinator provides the means for effective and economical implementation of the therapeutic program. The coordinator is a member of the community whose function is to help the therapist implement and coordinate the treatment plan by being in close touch with the patient, family, social network, and kibbutz systems that are involved in our work. Cases do not come with a coordinator; the role is suggested by the therapist, and the person is found by the family and the kibbutz representatives. It is understood that the coordinator will receive working hours from the kibbutz for any intensive and time consuming community work that needs to be done.

The goal with Karen was to help her develop a mature relationship with an adult that would support her as she re-established herself in her studies, her work, and leisure-time activities,. someone to whom she could also retreat whenever the situation at home was getting to a point of explosion. It was not difficult in this case to find a suitable person. Tamara, a divorcee with children who were already out of the home, was a longtime friend of the family. The two families, friends for a long time, have supported each other in the past.

Both Betty and Karen trusted Tamara and she agreed to take up the role.

Changing Ecosystemic Patterns that Maintain the Dysfunction:

Two parameters of dysfunctional transactions need to be handled on all levels of ecosystem: 1. structural dysfunctions, which are analyzed in terms such as boundaries, alignments, and power; and 2. narrative dysfunctions, which have to do with a constricted and biased construction of reality. The story which is presented to the therapist is usually focused on pathology in the past, present and future.

Structural dysfunctions

There were isomorphic organizational dysfunctions that appeared in all spheres of Karen's life: the family, the school, the medical team, the therapeutic system, and in the interfaces among these different systems. At the point of referral, there was a sense of loss of control over the crisis since Karen was being seduced by the power which her dramatic and debilitating seizures provided her, while on the other hand, the authority and executive functioning of the adults was weakened by fragmentation. There was Betty's sense of guilt, and there were the conflicts among the various adults, some of which were overinvolved with Karen, and some of which needed to become more involved. It was unrealistic to expect a resolution of all conflicts in one consultation, and so our strategy was to look together for some common goals and establish collaborative teamwork on this basis. Since the issue of limits was of particular concern at this stage of the crisis (otherwise community treatment would not be feasible), we focused the discussion on the following problems:

1. Karen's dangerous behaviors, which led to the persistent anxious monitoring of her by the mother, and to frequent fights between the two.

2. The periodic lack of compliance with respect to the medication. At the time Karen was

sedated too much. She wanted to stop taking all medicines, and her mother suspected (a suspicion that was later confirmed) that there were periods during which Karen was not taking her medicines. The present crisis followed such a period.

3. The lack of functioning at school and at work.

In the process of delineating limits and consequences, the executive control of the mother, and of the educational and the medical teams, was reaffirmed, and their respective domains were clarified. Betty agreed to support the teachers, *metapelet* and school-nurse (she was put in charge of monitoring Karen's medical condition), while Tamara was to coordinate the joint efforts, helping to deal on the spot with any conflict that may arise.

Narrative Dysfunctions

Narrative dysfunction are concerned with biases in the construction of reality which maintain the pathology, often by overfocusing attention on illness and disability. The adverse effect of the family's preoccupation with physical symptoms was demonstrated to them as they were asked not to be Karen's crutches in the session. Karen then managed to function without leaning on anyone, at times arguing her points with such alertness and forcefulness, that the mother's previous overconcern seemed ridiculous.

However, the story of Karen was not only constructed by the family. Larger systems too, participated in the writing of dysfunctional narratives that overemphasized pathology. Everybody was involved in creating a one-dimensional, monothematic type of a story: the mother and the brother, Dan, the neurologist and the nurses, the school teachers and *metapelet*, the classmates, and the therapist. At the center was Karen, the epileptic.

There is a need for a concept that deals with narratives that are particularly resistant to change and that can be applied to all levels of the ecology. I believe this concept is monoideism, a term which was introduced by Braid some 150 years ago to describe the

process of hypnosis. Kaffman (11) reintroduced and expanded this important concept, using it within a systemic approach. "The central element of the monoideistic pattern is the absorbing preoccupation with one set of persistent thoughts that become a powerful force of suggestions affecting cognition, emotion and behavior... and interpersonal transactions. Thus a self-contained feedback system is established, maintaining and reinforcing the monoideistic process" (pp. 118-119). Kaffman pointed out that this process occurs in diverse clinical conditions which are characterized by the predominance of compelling beliefs, including anorexia nervosa, paranoid disorder, obsessions and depressive states. It also plays a major part in many cases of refractory mind-body problems.

During a crisis, as well as in chronic situations, we may find a monoideistic narrative that is not only perpetuated by multilevel patterns, but also sustains the dysfunctional transactions. Hence the notion of a monoideistic narrative complements the concept of a rigid system (1). Both concepts are needed to explained the continuing impoverishment of the self and the family.

A critical intervention for arresting the monoideistic condition is to minimize the verbal and nonverbal communication about the disorder and related complaints. This point is included in a pact among the patient, the family and all other systems. Karen's mother agreed to stop her constant watch over Karen (this was made possible after the issue of limits was resolved), and all seizures were to be treated in a matter of fact manner without probing Karen about each experience. Furthermore, an agreement was made with the neurologist to transfer the regular medical monitoring of the epilepsy to the kibbutz physician, and to limit his contact with Karen. The neurologist was reassigned the role of the specialist following the case, consulted occasionally as needed. Individual therapy with Karen was to stop at this point, until her condition would be stabilized and she would wish to

resume therapy.

The Use of Social Resources to Support the Family and the Patient:

A major task of the treatment team is to support the patient and the family in filling their lives with productive activities, instead of with the preoccupation with the illness. This task is usually monitored in school by the educational team, while the coordinator is more involved with the after-school activities. They are all supervised by the therapist. Coordinators and other kibbutz representatives can be quite creative once they understand the logic of their task, often coming up with suggestions that neither the therapist nor the family considered before.

With Tamara's help Karen became integrated with a good working team in the kibbutz laundry. The team was understanding and supportive toward her and it soon became a place in which she felt responsible and competent, often working longer hours than officially required. Tamara also got Karen involved in a project of helping young children with developmental problems. Karen eventually became a group counselor, and she wrote a term paper about this project. In the first three months after the consultation, she and Karen met almost daily, and the tensions at home were considerably lessened. Tamara became a trusted adult friend with whom it was possible to discuss everything, except the seizures.

Karen's reinvolvement in school proved to be more difficult. Her homeroom teacher took responsibility for creating a study program in coordination with Karen and the other teachers. However, after a while it became clear that Karen was still behaving in school like a free student, making no efforts to reintegrate. At this point, the school, in collaboration with the family, threatened to suspend Karen. This crisis occurred three months after the consultation and it tested the cohesion of the large therapeutic system.

At first Karen seemed to comply with the school's conditions, but, a few weeks later, there was a dramatic increase in her seizures, and the tensions reached an all-time peak. After one particularly violent seizure Karen was hospitalized. A blood test indicated that she was not taking her medicines. The hospital's physician was worried about Karen's medical condition and threatened to transfer her to the psychiatric ward. Betty supported his position, much to Karen's surprise. The school too, decided that Karen would not be allowed back unless she proved herself responsible for taking care of herself, and showed more consideration for others (when the seizures were frequent they were very disruptive of class work). Consequently, when Karen returned to the kibbutz, after two days hospitalization, it was clear that there would be no more games with the medications.

This episode was a crucial turning point in Karen's self care, as well as school behavior. For a while, though, she was considering leaving school, and tried to provoke her mother with that threat. Part of the therapy was then devoted to creating a constructive working alternative for her. But once she realized that her mother and all the others agreed to this possibility, she began to see school in a more favorable light. It was also the first time that she began to think in a mature and realistic way about her future. At the end of the year her classmates were going to the army, while she would stay in the kibbutz. Completing her high-school education and getting a diploma became important to her, and at this point she became a regular student.

Another helpful intervention was accomplished by the school-nurse, in collaboration with the homeroom teacher. She had a discussion with the class, with Karen present, about their concerns and fears of the epileptic seizures. The way to handle them was clarified, as well as the overall objective of managing the illness in a way that would enable Karen to lead a normal life and interact with them as a peer, not an epileptic. After this discussion,

peer relations gradually became more normal. Karen's reinvolvement in studies, work and extra-curricular activities also contributed to her reintegration into the peer group.

Clarifying Boundaries between the Family and other Social Systems:

People tend to become very involved in a situation of crisis, especially if they are asked to play a part in the treatment. Unless the therapist keeps clear boundaries between the family and the involved social systems, new problems will be created, such as overintrusion, disempowerment of the family, and loss of privacy. Hence, the therapist needs to be sensitive not only to the overt conflicts in the large system, but also to the more subtle manifestations of boundary problems, such as the "innocent" questions of outsiders about the family dynamics, or their "by the way" remarks about the family's private sphere. It should also be remembered that the family-community relations have a history, and often there is more than one instance of unfinished business. But even in such situations, when collaboration seems like a mine field, family members and outsiders can join hands once they agree to pursue common, well defined, goals, and to do so under the professional guidance of the systems therapist.

In Karen's case, respect for the privacy of the family was underscored by the exclusion of outsiders from the room when the family dynamics were discussed. Later, when explaining the role of the coordinator, it was stressed that she was not a mother substitute, nor was she a mediator between Betty and her daughter. Other boundary problems with which we dealt were related to the relations among Betty, the *metapelet*, and the school-nurse. There was no direct dealing with the strained relations (this may be quite sticky in the kibbutz where people interact with each other on many different levels), but as there was an agreement on goals and strategies, it was possible to delineate the roles of the *metapelet*

and school-nurse. Betty became more supportive of their work with Karen, while they toned down their criticism of her mothering.

Follow-up

In most of our cases, the response to such a multilevel crisis intervention is positive, and the impact is seen immediately, often surprising clinicians who are not used to this type of work. This was also the response in Karen's case. As her medications were reduced and she became less drowsy, she resumed her studies, her work, as well as social and recreational activities. Everybody cooperated in diverting attention away from her illness. At this stage I "predicted" that it would take her a long while to fill her life with satisfying occupations, and that meanwhile she would suffer from a sense of emptiness. Karen was proud to prove me wrong.

The crisis that occurred three months after we began to work together is not infrequent, though the dramatic flavor is distinctly Karen's. It does take a few months in this type of situations until there is a more stable feeling that the crisis is over. At that point it becomes possible to deal with all the problems that led up to the crisis. In the present case, there was an eight-month course of family therapy. At times Karen was also seen individually, though she did not wish to go back to a full individual therapy. Many issues were discussed, including Karen's self-image and identity, mother-daughter relations, conflicts and difficulties in the creation of a blended family. In a natural way, Karen ceased to be the center of therapy, and some attention was given to her brother, the new couple and Dan's children. A year later the couple married. Karen graduated with good grades, and instead of going to the army, she volunteered to work with handicapped children. She was very successful in this work. Currently, three years after the initial consultation, Karen is

working in her Kibbutz and is applying for university.

CONCLUSION

Dysfunctional relations between the family and other social systems usually play a part in maintaining refractory problems and chronic patienthood. Therapeutic interventions need to work at this interface, in order to create a collaborative team that will provide sufficient support to the family at risk. This way of working can be easily applied in the highly organized community of the kibbutz, but the same principles have also been applied with urban patients. Members of the extended family, friends, close neighbors, members of the environment, physicians, and community agencies can become important therapeutic allies once we learn how to coordinate their resources.

In applying this approach therapists need to maintain contact with members of the community, and to find ways of involving them with the family, while at the same time taking care to respect family boundaries. This is a complex way of working, especially since the therapist needs to use a wide variety of techniques and apply them to different levels of the system. However, the intensive concentration of efforts during a crisis often enables the family to muster inner resources, eventually dealing with the problems in a more independent way.

REFERENCES

1. Andolfi, M., Menghi, P., Nicolo, A. M. & Saccu, C., Interaction in rigid systems: A model of intervention in families with a schizophrenic member. In M. Andolfi & I. Zwerling (Eds.), Dimensions of family therapy. New York: Guilford, 1980.
2. Bloch, D. A., Illness and family systems: A coevolutionary model. In C. N. Ramsey, Jr. (Ed.), Family systems in medicine. New York: Guilford, 1989.
3. Carl, D, and Jurkovic, G. J., Agency triangles: Problems in agency-family relationships. Family Process, 22(4): 441-451, 1983.
4. Coleman, S. B., An analysis of family therapy failures. In S. B. Coleman (Ed.), Failures in Family Therapy. New York: Guilford, 1985.
5. Elizur, J., "Whose pain is it?": Consulting at the interface between families and social-medical systems. In M. Andolfi and R. Haber (Eds.), Unsticking family therapy impasses: Professional and non-professional resources. New York: Brunner/ Mazel, to be published.
6. Elizur, J. & Minuchin, S., Institutionalizing madness, families, therapy and society. New York: Basic Books, 1989.
7. Frank, J. D., Persuasion and healing, a comparative study of psychotherapy. Baltimore: John Hopkins University Press, 1973.
8. Grifith, J. L., The mind-body problem revisited: Pseudoseizure patients. Family Systems Medicine, 8(1): 71-90, 1990.
9. Imber-Black, E., Families and Larger Systems. New York: Guilford, 1988.

10. Johnson, H. C.. Biologically based deficit in the identified patient: Indications for psychoeducational strategies. Journal of Marital and Family Therapy, 13: 337-348, 1987.

11. Kaffman, M., Twenty years of family therapy in Israel: A personal journey. Family Process, 24(1): 113-127, 1985.

12. Kaffman, M., Failures in family therapy: And then what? Journal of Family Therapy, 9: 307-328, 1987.

13. Schwartzman, J., Families and other systems: The macrosystemic context of family therapy. New York: Guilford, 1984.

14. Sloman, L. and Konstantareas, M. M., Why families of children with biological deficits require a systems approach. Family Process, 29(4): 417-429, 1990.

15. Wynne, L. C., McDaniel, S. H. & Weber, T. T., Systems Consultation for family therapy. New York: Guilford,1986.